

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5432

## CERTIFICATE OF DEATH

05423

Reg. Dist. No.

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by him, it shall be filed with  
 page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY <i>Caroline</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hillsboro</i>	c. LENGTH OF STAY IN 1b <i>20 yrs.</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Queen Anne</i>	d. STREET ADDRESS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Curtis</i>	Middle <i>E</i>	Last <i>Bledsoe</i>
4. DATE OF DEATH	Month <i>5</i>	Day <i>27</i>	Year <i>1959</i>
S. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5/18/1891</i>
9. AGE (In years lost birthday) <i>68 yrs.</i>		10. IF UNDER 1 YEAR Months <i>6</i>	11. IF UNDER 24 HRS. Days <i>1</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Factory</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>chicken</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Tice Bledsoe</i>	
14. MOTHER'S MAIDEN NAME <i>Lizzie Dalton</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) <i>No</i>	
16. SOCIAL SECURITY NO.		17. INFORMANT <i>MARY Bledsoe, W. Hillsboro, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1810</i>		INTERVAL BETWEEN ONSET AND DEATH <i>9 mos</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>16</i>
20f. (City or town) <i>Denton</i>	(County) <i>Denton</i>	(State) <i>Md.</i>	
21. I certify that I attended the deceased from <i>Sept 16</i> , 1959, to <i>May 24</i> , 1959, that I last saw the deceased alive on <i>Sept 23</i> , 1959, and that death occurred at <i>8:20</i> A.M., from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <i>Denton, Md.</i>	
ACTUAL SIGNATURE <i>Kurt Ledner</i>	M.D.	DATE SIGNED <i>5/27/59</i>	
PHYSICIAN'S NAME (Type) <i>KURT LEDNER</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>5/22/59</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Denton Cemetery</i>	22d. LOCATION (City, town, or county) <i>Denton, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Krause</i>	ADDRESS <i>Arthur S. Krause, Denton, Md.</i>	24a. REC'D BY REGISTRAR DATE JUN 8 '59	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05424

5433

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Caroline</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural</b>		c. LENGTH OF STAY IN 1b <b>45 yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Federalsburg, Md.</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>none</b>		d. STREET ADDRESS <b>none</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>Ada Briggs</b>		First <b>Brady</b>	Middle <b></b>	Last <b></b>	4. DATE OF DEATH <b>May</b>	Month <b>7</b>	Doy <b>19</b>	Year <b>59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 28, 1886</b>	9. AGE (In years lost birthday) <b>72 yrs.</b>	10. IF UNDER 1 YEAR Months <b></b>	11. IF UNDER 24 HRS. Days <b></b>	Hours <b></b>	Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME <b>John Johnson</b>			14. MOTHER'S MAIDEN NAME <b>Mary Camper</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Olin Briggs, Federalsburg, Maryland</b>		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <b>Coronary thrombosis</b> <b>Chronic myocarditis</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>8 yrs</b>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b>		20f. (City or town) <b></b>		(County) <b></b>	(State) <b></b>
21. I certify that I attended the deceased from <b>June</b> , 1954 to <b>May 1</b> , 1957, that I last saw the deceased alive on <b>May 7</b> , 1957, and that death occurred at <b>S.A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Frank W. Anderson</b> ADDRESS (Street, city or town, state) <b>Federalsburg, Md.</b> DATE SIGNED <b>5/9/57</b>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 9, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Skinner's Run</b>		22d. LOCATION (City, town, or county) <b>Federalsburg, Md. R. F. D.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Harvey W. Wilson</b>		ADDRESS <b>Federalsburg, Md.</b>		24a. REC'D BY REGISTRAR <b>MAY 12 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thorne</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1960

1960

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 5434 CERTIFICATE OF DEATH

Reg. Dist. No. 05425

1. PLACE OF DEATH a. COUNTY  Caroline		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Henderson		c. LENGTH OF STAY IN lb 3 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Arville		First Middle Brown	4. DATE OF DEATH Month 5 Day 4 Year 19 59
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/14/1905
9. AGE (In years ( <del>last</del> —birthday) yrs. 53	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer	11. KIND OF BUSINESS OR INDUSTRY None	12. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME William T. Brown	14. MOTHER'S MAIDEN NAME Ammie Mason	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 221-18-3037	17. INFORMANT James L. Brown 149 N. Queen St. Bel.	Address Dover	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 33IX DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Cerebral Hemorrhage General Arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While Nat while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Apr. 15, 19 59, to May 4, 19 59, that I last saw the deceased alive on May 4, 19 59, and that death occurred at 5:30PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles H. Stonesifer		ADDRESS (Street, city or town, state) Greensboro, Md.	
PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.		DATE SIGNED 5/7/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/7/59	22c. NAME OF CEMETERY OR CREMATORIUM Union	22d. LOCATION (City, town, or county) Goldsboro, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulaire	ADDRESS Greensboro, Md.	24a. REC'D BY REGISTRAR DATE MAY 11 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

REF ID: A6894

HEAD TO STAFFED AIRPORT

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **72 hours** after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05426

## 5435 CERTIFICATE OF DEATH

Reg. Dist. No.....

## 1. PLACE OF DEATH

COUNTY

CAROLINE

MARYLAND

CITY (If outside corporate limits, write RURAL  
OR  
TOWN and give nearest town)

JENTON

LENGTH OF STAY  
(In this place)

40 yrs

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

MD

COUNTY

CAROLINE

CITY (If outside corporate limits, write RURAL and give nearest town)  
OR  
TOWN

JENTON

STREET  
ADDRESS

(If rural give location)

3. NAME OF  
DECEASED  
(Type or Print)

(First) FRANK

(Middle)

(Last)

DENNIS

4. DATE  
OF  
DEATH

MAY 27

19 59

M

6. COLOR OR  
RACE7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

8. DATE OF BIRTH

Retired

10a. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

POLICEMAN

10b. KIND OF BUSINESS  
OR INDUSTRY

POLICE

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT  
COUNTRY?

USA

13. FATHER'S NAME

Washington DENNIS

14. MOTHER'S MAIDEN NAME

Sarah Emory

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.)

No

16. SOCIAL SECURITY NO.

17. INFORMANT &amp; ADDRESS

Mrs Harlan Edwards Denton

18. MEDICAL CERTIFICATION

19. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 IMMEDIATE CAUSE

(A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST. DUE TO

(C)



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5436

## CERTIFICATE OF DEATH

Reg. Dist. No.

05427

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Penna.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Greensboro</b>		c. LENGTH OF STAY IN lb <b>1 Yr.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Croydon</b>	
3. NAME OF DECEASED (Type or print) <b>Herman</b>		f. STREET ADDRESS <b>1040 Cedar Ave.</b>	
4. DATE OF DEATH <b>Month 5 Day 22 Year 1959</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/3/1893</b>
9. AGE (In years last birthday) yrs. <b>66</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Phila., Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Samuel Horn</b>		14. MOTHER'S MAIDEN NAME <b>Rebecca Mueller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>179-12-6278</b>	
17. INFORMANT <b>Alice Horn</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <b>Hypertension</b> DUE TO (c) <b>Passive Arterial Occlusion</b>	
		INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. MEDICAL CERTIFICATION	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 14, 1959</b> to <b>May 22, 1959</b> , that I last saw the deceased alive on <b>May 14, 1959</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>MARYLAND BLDG. MARYLAND, MD.</b>	
ACTUAL SIGNATURE <b>Robert H. Wright</b>		DATE SIGNED <b>May 23, 1959</b>	
PHYSICIAN'S NAME (Type) <b>ROBERT H. WRIGHT MD GREENSBORO MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/25/59</b>	
22c. NAME OF CEMETERY OR CREMATORIAL <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Somerton, Pa.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boalair Greensboro, N.C.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 25 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Anna</b>	

STATE OF TEXAS

1943 STATE CAPITAL

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

05428

## 543 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY  Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institutional: Residence before admission) a. STATE  Maryland		b. COUNTY  Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  Rural Greensboro		c. LENGTH OF STAY IN 1b  76 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)  X Rural Greensboro				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION  None				d. STREET ADDRESS  None		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)  James		First	Middle	Last	4. DATE OF DEATH July 9 1959	Month	Day	Year
5. SEX  Male		6. COLOR OR RACE  White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH  May 12 1883	9. AGE (In years last birthday) 79 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY  Farming		11. BIRTHPLACE (State or foreign country)  Maryland		12. CITIZEN OF WHAT COUNTRY?  U.S.A.		
13. FATHER'S NAME  Frank Hubbard		14. MOTHER'S MAIDEN NAME  Catherine Mitchell						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)  No		16. SOCIAL SECURITY NO  220-01-5074		17. INFORMANT  Martha Hubbard Greensboro, Maryland		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)				Cardiovascular Renal Disease  Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  Spastic Gastro-enteritis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)  Greensboro, Md.		(County) (State)
21. I certify that I attended the deceased from _____ Oct. 8, 1958, to May 9, 1959, that I last saw the deceased alive on May 8, 1959, and that death occurred at 5:30 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state)  Greensboro, Md.		DATE SIGNED 5/12/59
ACTUAL SIGNATURE  <i>Chas. H. Stonesifer, M.D.</i>								
PHYSICIAN'S NAME (Type)  Chas. H. Stonesifer, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify)  Burial		22b. DATE THEREOF  5/12/59		22c. NAME OF CEMETERY OR CREMATORY  Greensboro		22d. LOCATION (City, town, or county)  Greensboro, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE  <i>J. E. Boulaire Greensboro, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE MAY 15 '59		24b. REGISTRAR'S SIGNATURE  <i>Arthur S. Krause</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**FOR STATE  
HEALTH DEPT.**

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
5438 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05429

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived - If institution: Res dence before adm sion)		a. STATE Maryland		b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural Henderson		c LENGTH OF STAY IN lb 65 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Rural Henderson		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		None		d. STREET ADDRESS		None					
3. NAME OF DECEASED (Type or print)		First	Middle	Last		4. DATE OF DEATH	Month	Day	Year		
Jessie			Richardson	Hughes		1896	1	28	1959		
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH		9. AGE					
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1/9/1896		63	1 yrs				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Farm Laborer		None		Maryland		U.S.A.					
13. FATHER'S NAME		Alexander Hughes		14. MOTHER'S MAIDEN NAME		Mariam Satterfield					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		Unknown		Norval Hughes		Henderson, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocarditis Acute</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocarditis Chronic</u> DUE TO (c)											
INTERVAL BETWEEN ONSET AND DEATH Sudden Several yrs											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE  EXAMINER'S NAME (Type)		<u>Dawson O. George</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED  <u>2-28-59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county)		(State)			
Burial		5/31/59		Greensboro		Greensboro, Maryland					
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
<u>F. E. Paulais &amp; Greensboro, Md.</u>				JUN 1 '59		<u>Arthur S. Kraus</u>					



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05430

## 5439 CERTIFICATE OF DEATH

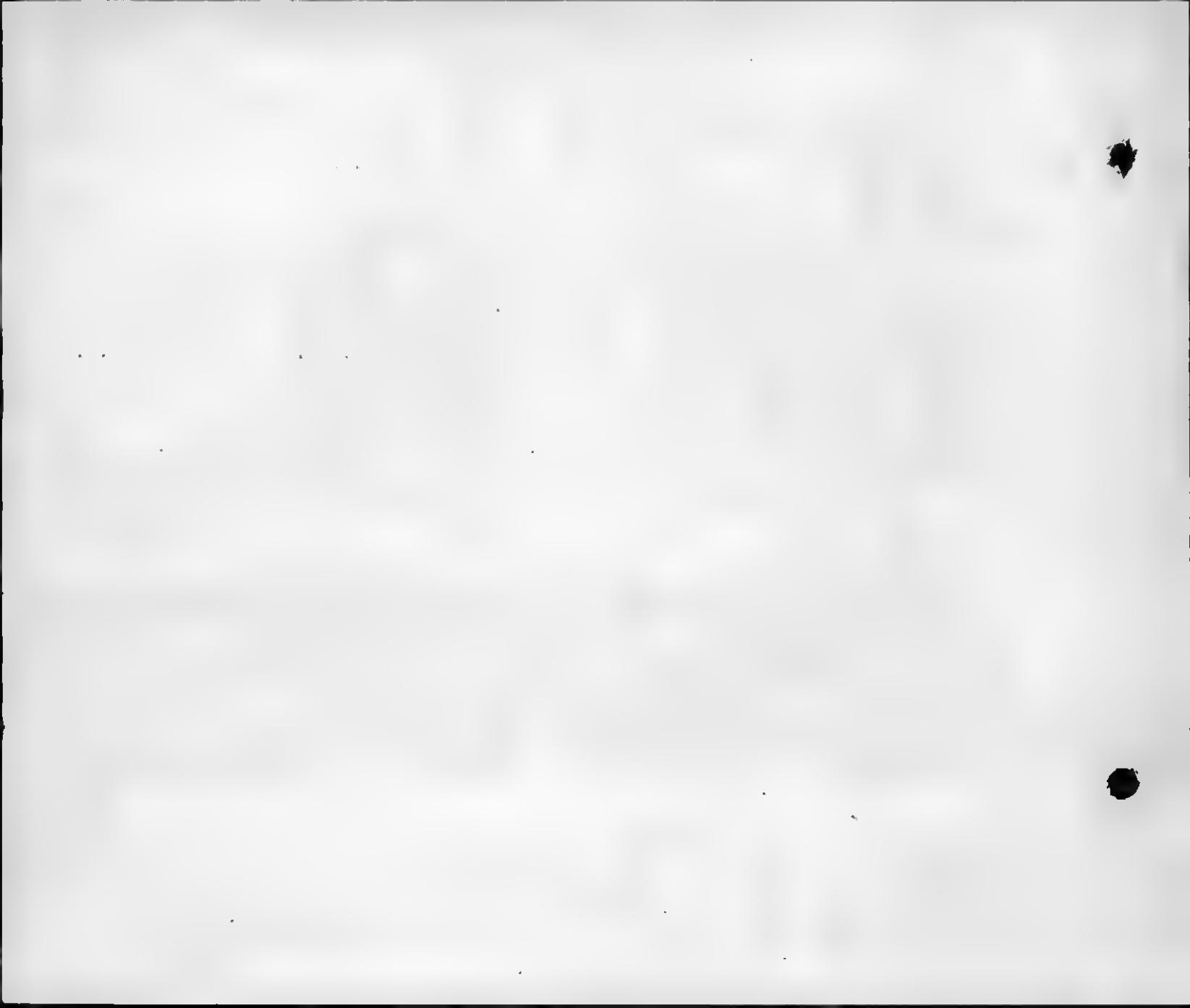
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Caroline</b>				2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE <b>Maryland</b>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Preston</b>				c. LENGTH OF STAY IN 1b <b>5 years</b>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Rural</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge, R.D. 3</b>						
d. STREET ADDRESS <b>Rural</b>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <b>Lambert</b>		First <b>Lambert</b>	Middle <b>Howard</b>	Last <b>James</b>	4. DATE OF DEATH <b>May 16, 1959</b>	Month <b>May</b>	Day <b>16</b>	Year <b>1959</b>		
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 8, 1874</b>	9. AGE (In years lost birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>		IF UNDER 24 HRS Days <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Talbot County, Md.</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.</b>				
13. FATHER'S NAME <b>John W. James</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Pritchard</b>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Franklin D. Musbaum, Preston, Md.</b>			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost <b>Generalized Artherosclerosis</b>				<b>Chronic Congestive Heart Failure</b>				INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>		
(b) DUE TO Causal Occlusion of large renal artery								30 "		
(c)								3 months		
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (6)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 20)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town) (County) (State)</b>				
21. I certify that I attended the deceased from <b>4/28</b> , 1959, to <b>5/17</b> , 1959, that I last saw the deceased alive on <b>5/6</b> , 1959, and that death occurred at <b>3:30 p.m.</b> from the causes and on the date stated above										
ACTUAL SIGNATURE <b>Dr. H. B. Plummer M.D.</b>										
ADDRESS (Street, city or town, state) <b>Preston, Md.</b>										
DATE SIGNED <b>5/19/59</b>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 18, 1959</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Greenlawn Cemetery</b>		22d. LOCATION (City, town, or county) <b>Cambridge, Md.</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth T. Thomas</b>		ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 21 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur &amp; Kline</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be delivered for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5440

## CERTIFICATE OF DEATH

Reg. Dist. No.

05431

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death: Page 4  
**may be retained by the hospital or attending physician.**  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <b>Caroline</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridgely</b>		c. LENGTH OF STAY IN 1b <b>50 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>None</b>		e. STREET ADDRESS <b>Maple Ave.</b>	
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <b>Ada</b>	Middle <b>Clara</b>	Last <b>Matthews</b>
4. DATE OF DEATH	Month <b>5</b>	Day <b>25</b>	Year <b>19 59</b>
5. SEX	6. COLOR OR RACE <b>Female</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/7/1871</b>
9. AGE (in years last birthday) yrs. <b>87</b>	10. IF UNDER 1 YEAR Months <b>0</b>	11. IF UNDER 24 HRS. Days <b>0</b>	12. IF UNDER 24 HRS. Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	11. BIRTHPLACE (State or foreign country) <b>Michigan</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Leanders S. Matthews</b>	14. MOTHER'S MAIDEN NAME <b>Martha Rosana Powers</b>	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	16. SOCIAL SECURITY NO. <b>None</b>	17. INFORMANT <b>Miss Stella M. Matthews Ridgely, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), sloping the underlying cause lost. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Generalized osteoporosis</b> —			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>fall</b>	
20c. TIME OF INJURY Hour o. m. p. m.	Month <b>Feb.</b> Doy <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Ridgeley, Md.</b>
20f. (City or town) <b>Ridgeley, Md.</b>	(County) <b>Caroline</b>	(State) <b>Maryland</b>	
21. I certify that I attended the deceased from <b>Aug. 1, 1953</b> to <b>Feb. 11, 1959</b> , that I last saw the deceased alive on <b>Feb. 11, 1959</b> , and that death occurred at <b>9 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. H. WINNACOTT</b>	ADDRESS (Street, city or town, state) <b>Ridgeley, Md.</b>		
PHYSICIAN'S NAME (Type) <b>C. H. WINNACOTT</b>	DATE SIGNED <b>5/26/59</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>5/27/59</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>Ridgeley</b>	22d. LOCATION (City, town, or county) (State) <b>Ridgeley, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Boulaire Greensboro, N.C.</b>	ADDRESS	24a. REC'D BY REGISTRAR <b>MAY 27 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>



## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 72 hours after death. After this bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

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## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 12 FilmG243 6-5-59 et

## 5441 CERTIFICATE OF DEATH

Reg. Dist. No.....

05432

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	MARYLAND LENGTH OF STAY (in this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	COUNTY RURAL STREET ADDRESS
CAROLINE MUSICAL DENTON		MARYLAND 3 days X CAROLINE RURAL DENTON	
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE (Month) OF DEATH</b>	
(First) ELIZABETH HEINEL THUNS		(Day) MAY 13 (Year) 1959	
<b>5. SEX</b> F	<b>6. COLOR OR RACE</b> W	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> widowed	<b>8. DATE OF BIRTH</b> JUNE 9, 1872
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Housewife		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> Home	<b>11. BIRTHPLACE</b> (State or foreign country) Germany
<b>13. FATHER'S NAME</b> Henry Dix		<b>14. MOTHER'S MAIDEN NAME</b> Appalona Kelly	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) no		<b>16. SOCIAL SECURITY NO.</b>	
<b>17. INFORMANT &amp; ADDRESS</b> Frederick Heinel Denton Md		<b>18. MEDICAL CERTIFICATION</b> Renal insufficiency, myocardial failure. Diabetes mellitus. Atherosclerosis. Generalized	
<b>I</b> DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 260X IMMEDIATE CAUSE (A). ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B). GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C).			
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)	
		M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from April 19, 1959, to May 12, 1959, that I last saw the deceased alive on May 12, 1959, and that death occurred at 6 P.M., from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> Charles H. Winnacott M.D. <b>DATE SIGNED</b> 5/18/59.			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> Burial		<b>DATE THEREOF</b> May 17, 1959	<b>NAME OF CEMETERY OR CREMATORIAL</b> Denton
<b>24. REC'D BY REGISTRAR</b> DATE MAY 22 '59		<b>REGISTRAR'S SIGNATURE</b> Arthur S. Kraus	<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> J. Wright Mooreton, Denton Md.
		<b>ADDRESS</b>	

